Davis Behavioral Health
HIPAA Procedures

Effective 4/14/03

Updated 09/09/2021

Policy 1 Uses and Disclosures: For Treatment, Payment, and Health Care Operation

Procedures

Uses and Disclosures for Treatment, Payment and Operations

Note: All uses and disclosures for treatment, payment and operations are subject to the right of the client to request restrictions on the uses and disclosures of their PHI. Davis Behavioral Health must comply with any restrictions to which we agree. For additional information, please see Policy 13, Other Individual Rights – Right to Restrict Uses and Disclosures of PHI.

Internal Uses and Disclosures of PHI for Treatment, Payment or Operations

1. It will be the responsibility of each employee who uses or discloses PHI for internal and external use to read and to understand the organization's Privacy Practices. These practices are outlined in detail in the current version of our Privacy Notice which is attached to the Privacy Notice Policy and Procedure. This notice may be amended from time to time.
2. In general, Davis Behavioral Health will use and disclose PHI for internal purposes without the client's explicit consent. However, Davis Behavioral Health will, except in emergency situations, provide each client with a copy of our Privacy Notice prior to their beginning a treatment relationship with us. This Privacy Notice details the types of uses and disclosures of their PHI that we make for treatment, payment and operations. Please see the Privacy Notice Policy and Procedure for more detail on this.
3. Psychotherapy notes are an exception to the general rule that Davis Behavioral Health will use and disclose PHI without permission of the client for internal treatment, payment and operations. The restrictions on use or disclosure of psychotherapy notes for either internal or external purposes is outlined below.
4. If an employee has any questions about whether or not a use or disclosure is permitted they must request assistance from either their supervisor or the Privacy Officer before making the disclosure or using the PHI.

External Uses and Disclosures of PHI for Treatment, Payment and Operations

1. **Treatment:** HIPAA regulations allow the use and disclosure of most PHI (psychotherapy notes and substance abuse information being exceptions to this general rule) to third party providers involved in the treatment of a client without the authorization of the client. However, Davis Behavioral Health will make our best effort to obtain a release of information from those clients prior to using and disclosing information to third parties in the area of treatment.

1. **Payment:** Davis Behavioral Health may disclose PHI to another healthcare provider to assist the provider in getting payment for services provided to one of our clients. However, in all cases, the PHI disclosed must only be the minimum necessary needed to secure payment. An example of this might be a situation in which Davis Behavioral Health has called an ambulance to transport a client in an emergency situation. The ambulance employees may not be able to obtain information at that time from the client for payment purposes. Consequently, the ambulance employee/company may need to contact Davis Behavioral Health afterwards for necessary information. In order to ensure that only the minimum necessary information is released and that the disclosure complies with our privacy practices, all billing employees will be trained in the minimum necessary disclosure philosophy maintained by Davis Behavioral Health:
    a. The billing department will be responsible for disclosures to other healthcare providers for payment purposes. .
    b. There will be written guidelines around the minimum necessary philosophy that will be developed by the HIPAA implementation team and approved by the ELT. The recommended guidelines on what Davis BehavioralHealth discloses to outside agencies for such purposes as “Minimum Necessary”Information includes:
        i. Client’s Attendance
        ii. Diagnosis
        iii. Initial Assessment
        iv. Treatment Plan
        v. Discharge Summary
        vi. Most Recent MD or APRN Progress Note

    c. Employees who have not been trained and do not have access to the written guidelines for disclosures must not, in any circumstances, disclose information to a third party who requests for their own payment purposes.

d. If the request is from a third party asks for additional PHI not listed in the guidelines the request must be sent to the billing supervisor for disposition.
e. In any cases where Davis Behavioral Health is releasing the entire record to a third party for payment purposes, we must justify why this is being done in writing and file this documentation in the medical record with a copy to the Privacy Officer. This should be documented on the "Accounting for Disclosures" form discussed in and attached to Policy 12, Individual's Right to An Accounting of PHI Disclosures.

2. **Operations:** PHI may be disclosed to a third party provider in certain limited circumstances for their operational needs. In all cases, the third party requesting the information must have or have had a relationship with our client and the information requested must be related to that relationship. For example, a lead agency may be trying to determine the types and kinds of services provided to the client referrals it made to various programs. The information is going to be used in its Quality Improvement process. If the information, they are requesting is about the time period during which we were providing services to the client and they were the lead agency we can release the information. However, the information released must comply with the minimum necessary standards. On a routine basis, Davis Behavioral Health may release information to the carve-out behavioral health contractor or to the State Division of Mental Health to assist them in service planning or in their utilization management efforts. However, because of the complexity of determining what is or is not a permitted disclosure, the following procedure will be followed:
    a. The Privacy Officer will be responsible for all disclosures to third parties requested for that third parties' operations.
    b. This responsibility may be delegated to trained employees or business associates who follow instructions for each type of routine request the organization receives for information for the operations of a third party provider.
    c. The instructions must be developed by the Privacy Officer, who is under the supervision of the CEO. The instructions will list the disclosures allowed to each third party specifically, and a procedure for ensuring that the provider requesting the information has or has had a relationship to the client and the PHI requested is related to the relationship the third party has or had to the client, and the PHI disclosed is the minimum necessary for the operational purpose contemplated.

d. Employees who have not been trained and do not have access to the instructions for disclosures must not, in any circumstances, disclose information to a third party who requests for their own operations purposes.
e. If the request is from a third party that has not had a relationship with the client, requests additional PHI, or is for an operational reason not contemplated in the instructions, the request must be sent to the Privacy Officer for disposition.
f. In any cases where Davis Behavioral Health is releasing the entire record to a third party for operational purposes, we must justify why this is being done in writing and file this documentation in the medical record with a copy to the Privacy Officer. This should be documented on the "Accounting for Disclosures" form discussed in and attached to Policy 12, Individual's Right to An Accounting of PHI Disclosures.

3. All other requests for disclosures of PHI to third parties whether or not they are covered entities will require a signed authorization by the client.
4. If an employee has any questions about whether or not a use or disclosure is permitted, he/she must request assistance from either his/her supervisor or the Privacy Officer before making the disclosure or using the PHI.

Psychotherapy Notes

Any request for the use and disclosure of psychotherapy notes by anyone other than the originator of the notes for treatment purposes must be the approved by the Privacy Officer. In most cases, an authorization by the client will be required. The exceptions to this will be in the case where:

1. The Privacy Officer has approved use of Notes in an internal training program for treatment staff that is appropriately supervised.
2. The Notes are used to develop a defense against a legal action brought by the client against the organization or the provider. The Privacy Officer in conjunction with legal counsel will determine the need for use and disclosure of the psychotherapy notes to assist in the defense.
3. In other situations in which the disclosure is required by law or regulation to assist in health care oversight, to determine or investigate the organization's compliance with the Privacy Regulations under HIPAA, and to assist law enforcement in certain limited situations. In each of the situations described in this paragraph, the Privacy Officer must be consulted. He/she, with advice from legal counsel, will determine if there is a need for the disclosure and the extent of the disclosure of psychotherapy notes.

In all cases the development or use of psychotherapy notes to assist in psychotherapy will be restricted to mental health professionals in the organization. The measures the treating professional will take to secure these notes must have the approval of the Privacy Officer.

Substance Abuse Disclosures

Any PHI disclosed without authorization of a client in a federally-assisted substance abuse program may only be made in consultation with the Privacy Officer.

Policy 2 Uses and Disclosures: Authorizations

Procedures

Determining Which Disclosures Require an Authorization

The first determination each staff person must make before disclosing Protected Health Information either internally or externally or before requesting the disclosure of PHI from another entity or provider is whether or not the disclosure or request requires an authorization from the individual. In any case where a staff person is unsure about whether or not an authorization is needed before making a request for PHI or before making a disclosure of PHI, they should contact their supervisor or the Privacy Officer.

In all cases, whether the disclosure for an internal use or for a third party external to the organization, employees should follow the guidelines found in the Minimum Necessary policy for determining the type and amount of PHI that should be disclosed.

In all cases where an authorization is required, the staff person must make sure that the individual understands that their treatment is not conditioned on whether or not they sign an authorization. This assurance is included in writing on every authorization form. The only exceptions to this are for research related treatment and in situations where the purpose of the treatment is specifically for disclosure to a third party, (i.e., a consultation).

Internal Disclosures

Most internal disclosures to other Davis Behavioral Health employees and contractors are permitted without an authorization, if the purpose of the disclosure and the intended use of the information disclosed is for treatment, payment, or health care operations. One major exception to this is for psychotherapy notes, which require an authorization for internal use except in certain limited circumstances. Please see Policy 1, Uses and Disclosures for Treatment, Payment, and Operations.

Sharing of PHI for Treatment Among Current Treatment Team Members

In general, the HIPAA regulations encourage the sharing of the PHI needed for treatment among members of the current treatment team for the client. This team can be individuals who are internal or external to the organization, and can include providers who are in an indirect treatment

relationship, (i.e., laboratories that do not deal directly with the client but are an important source of information for treatment purposes).

Clients are informed of our intention to share information among treatment team members in our Privacy Notice. The one major exception to this general rule is psychotherapy notes. These notes require a signed authorization by the client for disclosure both internally or externally except in very limited circumstances. Authorization for the disclosures of psychotherapy notes cannot be combined with any other authorization.

Sharing of PHI Needed for Payment and Operations Among Covered Entities and Healthcare Providers

1. PHI that is needed by another covered entity or healthcare provider in order to seek payment for services provided **by Davis Behavioral Health** to a client can be disclosed or requested without an authorization.
2. PHI that is needed by another covered entity or healthcare provider in order to seek payment for services provided **by them** to one of our consumers can only be disclosed pursuant to the Policy 1, Uses and Disclosures for Treatment, Payment and Operations.
3. PHI that is needed by another covered entity or provider for **certain** operations may be disclosed or requested without an authorization. The operations are generally those in which Davis Behavioral Health participants either directly or indirectly, for example, giving service delivery information to a managed care organization in order for them to conduct utilization management or quality improvement activities. Disclosures of PHI for the operations of a third party can only be made pursuant to Policy 1, Uses and Disclosures for Treatment, Payment, and Operations.

Disclosures to Business Associates

Disclosures to our business associates are permitted without an authorization but the information must be limited to the information they need in order to accomplish the work we require of them. Please see Policy 5 on Business Associates for information on how to determine who is a business associate and how to determine whether the disclosure of PHI is permitted and what types of PHI can be disclosed.

Other Disclosures That Do Not Require An Authorization

Disclosures that are:

1. Made for the health oversight activities of federal, state and private regulators and payers, including those responsible for determining whether or not we are in compliance with the Privacy Regulations of HIPAA,
2. Required by law, or
3. Made because of an imminent threat to life and safety, can be made without an authorization and are explained in our Privacy Notice.

There are other disclosures as well that may be made without an authorization. Please see Policy 4 on "No Permission". Any disclosure made for any of the above reasons should be approved by the Privacy Officer prior to the disclosure where possible, and within 24 hours of disclosure where prior notice is not possible.

The above disclosures must be documented on a "PHI Disclosure To Be Included in Client's Accounting Form" and filed in the medical record. Please see Policy 12, Accounting for Disclosures, for additional information.

Disclosures That Do Require An Authorization

Disclosures either internally or externally that **do** require an authorization are those in which:

1. The PHI requested is the content of psychotherapy notes (there are very few exceptions, please see Policy 1, Uses and Disclosures for Treatment, Payment and Operations).
2. The PHI requested or disclosed is not going to be used for healthcare purposes, for example fundraising communications made without authorization are subject to several conditions and restrictions. The Privacy Officer should approve any requests for disclosures for fundraising purposes.
3. The PHI requested or disclosed is for treatment but is being requested of a covered entity or provider who is not a current member of the treatment team (i.e., requesting parts of a record from a prior provider).
4. The PHI requested or disclosed is for treatment purposes, but the treatment team member is not part of our workforce or not a healthcare provider (i.e., developing a treatment plan with the school a child attends).
5. The PHI requested or disclosed is for the operations or payment needs of another covered entity or healthcare provider but it does not meet the conditions outlined above under, "Sharing of PHI Needed for Payment and Operations Among Covered Entities and

Healthcare Providers" or in Policy 1, Uses and Disclosures for Treatment, Payment and Operations.

PROCEDURES FOR COMPLETION OR FOR PROCESSING AN AUTHORIZATION

A. Requesting PHI Pursuant to an Authorization

1. Please see the attached authorization form, which includes certain instructions for completion, attached to this policy. This is the most current approved form and should be used by all staff members to request PHI disclosures either internally or externally.
2. The need for the PHI being requested should be explained to the individual.
3. Every individual should be informed that their continued treatment at Davis Behavioral Health is not dependent on whether or not they sign the authorization, except for research related treatment and in situations where the purpose of the treatment is specifically for disclosure to a third party. This information is included in writing on the authorization form and should be reviewed with the client.
4. The form should be reviewed and completed fully when the individual requesting the authorization is present. In cases where the client or other authorized individual is not present and has requested that a form be sent to him/her for signature, the staff person receiving the request should, if possible, review the form with the requestor and complete as much of it as possible before sending it out for completion and signature. In particular the following issues should be discussed, if possible:
    a. To whom the request should be directed. This information should be completed as specifically as possible. For example, it is best to send a request directly to a treating professional rather than to the agency in which the treating professional is employed. If the name of the person is not known, the request could be sent to the medical records department or to the site where treatment occurred.
    b. A description of the purpose for which the disclosure is needed. Please be specific about whether the disclosure is needed for treatment, payment, operations or a combination of two or more of these reasons. A statement "at the request of an individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not, to provide a statement of their purpose.
        i. If the request is for treatment you do not need to be more specific unless the treatment involves substance abuse and the provider is a

federally-assisted substance abuse program or unless the PHI requested contains HIV status information.

ii. If the request is for operations, you should describe the type of operations (i.e., utilization management).

iii. If the request is for payment purposes, you should be specific about dates and times of treatment.

iv. If the PHI is needed for a reason other than treatment, payment or operations, please specify the actual use (i.e., the information is needed to create a database of individuals with similar circumstances to conduct research).

c. The PHI that you would like to be disclosed: Each request is governed by Davis Behavioral Health's policy on Minimum Necessary. Please see this policy for guidance on requesting and disclosing PHI. After determining the minimum amount of information needed for the disclosure, you should be specific in your request (i.e., the parts of the medical record you wish to be disclosed, the dates of treatment you are interested in, etc.).

d. How long does the authorization need to be in effect?

i. If the disclosure is a one-time event (i.e., the copying and mailing of medical records), this event can be specified. The event listed in the disclosure must relate to the client or to the purpose of the use and disclosure. If you intend to follow up the review of the records with a discussion with the disclosing professional, you would want to ensure you indicate on the authorization the time to do this.

ii. Once you have determined how long you will need the authorization to be in effect, specify on the form (either the date or the event that is most specific) in detailing the boundaries of the authorization. The statement "end of the research study", "none", or similar language is sufficient if the authorization is for a use or disclosure for research, including for the creation and maintenance of a research database or research repository.

e. Have the individual and/or his/her legal representative sign the authorization.

f. Make two copies of the completed form.

i. One copy should be given to the individual for their records.

ii. The second copy should be kept in the medical record. A note should be made on this copy that the client was given a copy of the authorization. This entry should be dated and signed.

g. A copy of the original should be mailed or faxed to the person(s) or entity specified on the authorization.

h. All authorizations should be kept for six years from their last effective date.

B. Disclosing PHI Pursuant To An Authorization Received From A Third Party

1. The person receiving the authorization should check to see who is listed on the form as the disclosing professional. The authorization may list an individual or the titles or role of the person to whom the authorization is directed.
   a. If the person listed on the authorization is currently employed at Davis Behavioral Health, the authorization should be given directly to him/her to process.
   b. If the person listed on the authorization is not currently employed at Davis Behavioral Health, the authorization should be given directly to the medical records department.
      i. The medical records department will determine if the release is complete and will act on it directly or will delegate it to the appropriate individual in the organization to process.
2. Upon receipt of an authorization for disclosure of PHI, the person to whom it is directed should, review the form to determine if it is complete and specific. In particular, the following items should be reviewed:
   a. Is the form signed by the individual who is the subject of the disclosure?
   b. Is there a date or specific event listed that defines the period during which the authorization is in effect? Is the authorization, based on this information, still in effect?
   c. Is the information being requested specific enough so that it can be acted on? Is it clear what PHI is being requested?
   d. Is the purpose of the disclosure explained? This is necessary only when the PHI being requested is related to the substance abuse treatment of the client, the client's HIV status or the requestor is a covered entity and is requesting the PHI for their own use or for disclosures by others.
   e. Is the amount and type of PHI requested reasonable and necessary given the purpose of the request?

If yes to all the above, the disclosure can be approved. If no, the staff person to whom the disclosure is directed should determine whether or not he/she will refuse to make the disclosure at

all or whether they will make a partial disclosure. If the staff person is unsure or believes the authorization is excessive or not warranted, he/she should consult with their supervisor or the Privacy Officer. If there is agreement that the authorization is not warranted or may be excessive, the staff person should make a good faith effort to contact the consumer to explain his/her concerns and to determine if the consumer still wishes the authorization to stand as written or will modify and resubmit it.

3. If the staff person to whom the authorization is directed believes that the authorization should be complied with in its entirety, he/she should approve of the authorization (for example, write OK, write their initials, and write the date at the bottom of the authorization form).
    a. If the disclosure is an oral disclosure, he/she should complete the consultation or discussion and document the date, time, list all those participating in the discussion, and the content of the conversation in the medical record of the individual if there is a current and open record or on the back of the authorization form or on a piece of paper attached to the form for filing in the closed medical record of the individual.
    b. If the disclosure is to be in writing, a copy of the correspondence should be attached to the authorization form and placed in the medical record.
    c. If the disclosure requires copies of documents from the designated record set, the authorization form should then be directed to medical records or other administrative staff who will gather the information, copy it, and send it as directed in the authorization.
        i. Once the information has been sent, the person completing this task should write sent, specify how it was sent (mail, email, fax), date and initial the bottom of the form.
        ii. The form should then be filed in the medical record. Authorizations should be maintained in the current record for six years from their last effective date.
4. If the staff person, to whom the authorization is directed, does not believe that a disclosure should be made at all or believes that the authorization is not valid, he/she should write a note on the bottom of the authorization stating the reasons for non-compliance with the authorization, initial and date the form.
    a. A letter should be mailed to the entity or person requesting the disclosure explaining the reasons for non-compliance with the disclosure.
    b. A copy of the letter should be stapled to the original authorization and kept in the medical record.
    c. If the staff person to whom the authorization is directed has determined that it can be partially complied with, he/she should specify on the bottom of the authorization, the

exact information to be released, date and initial the note. The staff person should then follow one or more of the options listed in #3 above for disclosing the PHI requested.

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Policy 3 Uses and Disclosures: Opportunity for the Individual to Agree or Object

Procedures

Facility Directories

A. There will be no facility directory either posted or held by reception for informing callers or visitors if a client is on-site receiving services or a current or former client of Davis Behavioral Health.

B. No staff person should confirm orally, in writing, or through any other medium that a client is either on-site or a current or former client of Davis Behavioral Health, with the exceptions listed below under "Disclosures to Person's Involved in an Client's Care".

Disclosures to Person's Involved in an Client's Care or for Notification Purposes

A. Guardians, and Other Legal Custodians

1. At times, Davis Behavioral Health will have clients who are not able to direct or make decisions about any or some of their health care. In all cases, the authority of someone else to direct or decide about the health care of a client, and to, therefore, have access to the PHI necessary to make decisions or direct care, must be verified by the appropriate documentation as listed below. This documentation will outline the authority of the client and the limits to that authority. In all cases, this documentation must be reviewed by the ELT representative, who should consult with the Privacy Officer or Counsel, if he/she does not understand the limits or extent of the authority being granted. In all cases, the decision to disclose and the extent of the disclosures to be made must be carefullyand clearly communicated to the treatment team members by the ELT representative. See also below for medical record documentation requirements.
2. In every case where some or all of the authority for decision-making has been granted to someone other than the client, the medical and billing records must be flagged.
3. Any employee who is accessing PHI at the request of an agent, guardian, monitor or state entity assigned custody should:
    a. If a member of the treatment team, ensure that they clearly understand the limits of the disclosures of PHI that can be made.

b. If not a member of the treatment team, consult with the treatment coordinator on the treatment team to determine if the disclosure should be made.
c. In either case, if there is any confusion, consult with the ELT representative or the treatment coordinator **BEFORE** making anydisclosure.

4. Withholding PHI: if a treatment team member believes that, even though a disclosure of PHI is authorized, disclosure of the information will cause harm to the client he/she should:
   a. If the treatment coordinator, make the decision to not disclose and document the decision in the medical record including the reasons why, in his/her professional judgment, the PHI was not disclosed.
   b. If not the treatment coordinator, the team member should consult with the treatment coordinator who will make the decision and follow the procedure in a) above.

B. Family Members, Partners, and Others Authorized by Client to be Involved in Client's Care
   1. Many clients, who receive treatment at Davis Behavioral Health, choose to have family members, significant others, friends, and other community supports involved in their care on a regular, on-going basis. This is something Davis Behavioral Health encourages because it is often beneficial to the client's ability to successfully integrate and stay in the community. However, it is important that before any PHI is disclosed to these individuals, we understand the client's wishes with regards to these disclosures and we offer them an opportunity to object or agree to the disclosure.
      a. In all cases, the PHI disclosed must be limited to what is directly relevant to the person's involvement in the <u>current</u> care of the client or to the payment for services delivered to the client.
      b. Staff persons who make disclosures pursuant to this procedure should, in addition to documenting the disclosure, record the nature and the duration of the relationship, if known.
      c. In all cases, the client must be offered the opportunity to agree or object to the client's involvement in a private area. If the treating professional believes that this involvement will be regular and consistent in content, he/she can document the verbal permission of the client in the medical record, which should include the date the permission was given by the client, and the names of the individuals

to whom disclosures can be made. This permission can be given at any time during the current treatment episode. (Note: In all cases, before disclosing information to someone involved in the client's care, the medical record should be consulted). Employees who are not a part of the treatment team should not be responsible for disclosing information to individual's involved in the client's care and should refer all inquiries to the treatment coordinator or a treatment team member.

2. In some cases, the client will not want another involved in his/her care except on a very limited basis or only in a specific circumstance.
    a. In these cases, the client must be present to give their permission directly to the treatment team member.
    b. The employee should take the client to a private location and should ask for his/her agreement or objection and should discuss the limits of the disclosures the client wishes to be made.
    c. The client's agreement and the disclosure made should be documented in the medical record only if material to the client's care. For example, another individual's participation in a counseling session should be documented in the progress note along with confirmation of the client's permission. If permission has been given only to inform another of the next appointment date, this does not need to be documented. The judgment of the disclosing employee should determine whether or not a disclosure needs to be documented.
3. If the client has presented as an emergency and:
    a. Is not capable, in the judgment of the treating professional, to agree or object, and
    b. The treating professional believes the disclosure is in the best interests of the client, then
    c. The disclosure of the minimum necessary PHI can be made to the individual. This disclosure should be documented in the medical record along with the reasons the treating professional believed the disclosure should have been made.
4. If the client is not present and there has been no permission given to disclose information to another individual as documented on the demographic form in the medical record, then a disclosure of PHI cannot be made.

5. In all cases, if the treatment team members or other professionals they have consulted believe that the disclosure of PHI, even if agreed to by the client, may cause harm to the client or others, he/she should refuse to make the disclosure.

C. Disclosures for Disaster Relief Purposes

Disclosures for notification purposes may be made to a private or public entity charged by law or by charter to assist in disaster relief efforts.

1. The PHI needed for notification purposes includes the name, location, and general condition of the client.
2. The requirements described in #3.c. above apply in these circumstances unless it is determined that the procedures will interfere with the ability of the relief agency to respond to the emergency situation.

The decision about whether or not to disclose in these circumstances should be made by the ELT representative, unit manager, or senior staff person on site at eachagency location.

Policy 4 Uses and Disclosures: No Permission Required

Procedures

1. In most cases, the decision about whether to disclose without the individual's consent, authorization or agreement will be made by the Privacy Officer in consultation with the treating professional or other direct care staff person involved in the individual's treatment. The Privacy Officer may delegate this responsibility to others in the organization pursuant to a standing order for disclosures that are routine or on a case-by-case basis, and the Privacy Officer will contact the agency attorney if additional legal assistance is needed.
2. Many of these disclosures need to be accounted for to the individual should they request a list of disclosures, (see Individual's Right to an Accounting of Disclosures of PHI Policy). Because of this, it is very important that staff carefully record the date, the PHI disclosed, the reason for disclosure, and to whom the disclosure was made on the PHI to be included in Client's Accounting Form. This form should be filed in the medical record. Davis Behavioral Health must be able to account for certain disclosures for up to six years. Please see the Policy 12 for additional information and instructions.
3. When a court order is required to disclose PHI, the requested PHI and proposed disclosure process will be reviewed under the direction of the Privacy Officer. When appropriate, the Privacy Officer or his designee will consult with our agency's attorney before releasing PHI pursuant to a court order or before declining to do so because the request is not in the form of a proper judicial order. Whenever we are permitted to disclose PHI pursuant to a subpoena (see "Judicial and Administrative Proceedings" above), we will receive satisfactory assurances that:
    a. The PHI is not privileged information; or
    b. If the PHI is privileged, the client, or DBH on the client's behalf, has the opportunity to assert the privilege.

    If Davis Behavioral Health is uncertain as to whether the above requirements seem sufficient to protect the privacy interests of the individual, we will ask our lawyers to advise us about the proper method of disclosing PHI. We may decide, in connection with our legal consultation, to provide our own notice to the individual, to obtain an authorization from the individual, to seek a proper judicial order to release the PHI, to object to or (or request the court to) quash the subpoena, or to seek our own qualified protective order.

4. In other cases, the disclosure can be made without prior notice to the individual, but as soon as practical afterwards, the individual must be informed that the disclosure was made. In all cases, the Privacy Officer or his designee in consultation with the treating professional or direct care provider will determine who should be responsible for notifying the individual about the disclosure. The notification, time, and date should be recorded on the Accounting for Disclosures Form and signed by the individual responsible for notifying the individual. All notifications to the individual about a disclosure may be made orally, but can be made using electronic or written communication.
5. Some of the disclosures discussed in this policy and procedure are mandated by law (i.e., reporting child abuse). In these cases, the Privacy Officer should be informed of the disclosure, but does not need to approve it. Each individual, who is mandated to report or has a legal obligation to report, cannot be overruled by the opinion of another staff person. However, ELT members, supervisors, senior clinical staff, and the Privacy Officer are available for consultation with any staff person who is unsure of whether or not a disclosure should be made.
6. In some cases, the staff person making the disclosure may believe that by disclosing to either the individual, to the individual's parents or guardians, or to others involved in the care of the individual, he/she is endangering the individual. In most of these cases, the staff person has an obligation to protect the safety of the individual and to not disclose even if it is permitted. Only professional treating staff should make this decision. Other direct care providers should consult with their ELT representative, clinical supervisor, or the Privacy Officer prior exercising the agency's right to not disclose. The staff person should notify the Privacy Officer if possible prior to the decision not to disclose and, in all cases, within 48 hours after the decision is madenot to disclose.
7. The following table lists the types of permitted disclosures, who can make the decision, and the notification requirements for each type

Reason for Disclosure	Limits on the Disclosure	Who can make the decision?	Does the individual need to be notified?	Accounting for Disclosure Form needed?
Public Health uses including surveillance, investigations, and interventions.	Limited to the relevant PHI required by law	Privacy Officer	No	Yes
Reporting child abuse to appropriate authority	Limited to the relevant PHI required by law	Staff person mandated to report	No	Yes
Reports to the FDA if required by law to report adverse events or product defects	Limited to the relevant PHI required by law	Privacy Officer	Yes	Yes
Notification required by law of the exposure of an individual to a communicable disease	Limited to the relevant PHI required by law	Privacy Officer or Senior Manager at Site pursuant to a standing order	Yes	Yes
Notification to an employer of work related injuries or workplace surveillance	Limited to the PHI relevant to the workplace injury	Privacy Officer or Senior Manager at Site pursuant to a standing order.	Individual must be notified of this practice in Privacy Notice if organization intends to notify employers	Yes
Disclosures required by law to report victims of abuse, neglect or domestic violence (other than child abuse)	Limited to the relevant PHI required by law	Staff person required to report	Yes, unless, the disclosing staff person believes the individual would be placed at risk or harmed by the notification or the disclosure is to be made to a personal representative who the staff person believes is responsible for the abuse, neglect, or injury and that disclosure would not be in the individual's best interest.	Yes

Reason for Disclosure	Limits on the Disclosure	Who can make the decision?	Does the individual need to be notified?	Accounting for Disclosure Form needed?
Disclosures to authorized agencies or law enforcement where the report is not required by law to report victims of abuse, neglect or domestic violence, or other crimes where the staff person believes there is a serious threat to the individual or other potential victims	PHI limited to the information relevant to the suspected abuse	Treating professional or direct care provider in consultation with their supervisor	Yes, unless, the disclosing staff person believes the individual would be placed at risk or harmed by the notification or the disclosure is to be made to a personal representative who the staff person believes is responsible for the abuse, neglect, or injury and that disclosure would not be in the individual's best interest.	Yes
Disclosures to report victims of abuse, neglect or domestic violence, or other crimes where the individual is incapacitated and the official receiving the information states that they do not intend to use the information against the individual and non-disclosure would adversely affect the enforcement effort.	PHI limited to the information relevant to the suspected abuse	Treating professional or direct care provider in consultation with their supervisor.	Yes, as soon as is practicable unless, the disclosing staff person believes the individual would be placed at risk or harmed by the notification or the disclosure is to be made to a personal representative who the staff person believes is responsible for the abuse, neglect, or injury and that disclosure would not be in the individual's best interest.	Yes
Disclosures to agencies charged with health oversight	PHI should be relevant to the oversight of the healthcare program, to beneficiary eligibility, or to regulatory requirements to determine compliance with program standards	Privacy Officer or other staff person designated by the Privacy Officer pursuant to a standing order for routine disclosures.	No	Yes

Reason for Disclosure	Limits on the Disclosure	Who can make the decision?	Does the individual need to be notified?	Accounting for Disclosure Form needed?
Disclosures pursuant to court orders, for subpoenas, or similar processes – see Subpoena Policy	PHI must be limited to the scope of the order	Privacy Officer must be consulted as soon as is practicable. The Privacy Officer will consult with the agency's attorney who will advise on the response and disclosure, if made.	Yes	Yes
Disclosures of limited amounts of PHI to law enforcement to identify a suspect, fugitive, material witness or missing person	Limited to identifying information only	Privacy Officer	Yes	Yes
Disclosures of PHI to coroners or medical examiners for identification of deceased persons or to determine cause of death	PHI released should be limited to the information relevant to the identification or determination of death, but can, where necessary, include the disclosure of psychotherapy notes	Privacy Officer	No	Yes
Disclosures to funeral directors to perform their legal duties	Limited to the PHI necessary for them to safely perform their duties.	Privacy Officer	No	Yes
Disclosures to organ procurement and similar organizations	Limited to the PHI necessary for them to safely perform their duties.	Privacy Officer	No	Yes
Disclosures for research purposes where: ▪ There is an approved waiver of authorization ▪ The researcher makes certain representations regarding the necessity and security of the PHI ▪ Where the individual is dead and the PHI is only for and necessary to the research.	Limited to the PHI relevant to the research protocol	Privacy Officer	No	Yes
Disclosures necessary to avert a serious threat to health and safety – see Policy on Duty to Warn.	Limited to the PHI essential to adequately comply with the law regarding disclosures to avert serious harm or threats to health and safety	Privacy Officer, if practicable. Senior clinical manager on site in cases where it is not practicable to delay the disclosure	No	Yes

Reason for Disclosure	Limits on the Disclosure	Who can make the decision?	Does the individual need to be notified?	Accounting for Disclosure Form needed?
Disclosures for military activity, national security and other similar activities	Limited to the PHI necessary to adequately comply with the request for disclosure	Privacy Officer in consultation with legal counsel if this is practical. Senior clinical manager on site in cases where it is not practicable delay the disclosure	No	Yes. If allowed by security considerations.
Disclosures to correctional institutions where the PHI is needed to provide healthcare, for health and safety reasons, or to ensure the good order of the institution	HIPAA does not provide protection for incarcerated individuals. It is the agency's policy to act in the best interest of public safety	Treating professional, direct staff person	No	No
Disclosures for Worker's Compensation	Limited to the PHI relevant to the injury claimed by the individual	Privacy Officer in conjunction with legal counsel.	No	Yes
Workforce Whistleblower	Limited to the PHI relevant to practices being reported	Workforce member making report	No	Yes, when DBH is made aware of the report

Policy 5 Uses and Disclosures: Business Associates

Procedures

1. The Privacy Officer in consultation with the CEO, CFO and legal counsel, as needed, will be responsible for developing and maintaining a list of the agency's business associates.
    a. All staff will report to the Privacy Officer any time they are considering the development of a business relationship with another individual or organization that will use PHI created or disclosed by the agency to conduct agency-related work.
        i. Staff should assume that most relationships with outside individuals or agencies that are not treatment related could be business associate relationships and should contact the Privacy Officer to determine if a business associates agreement is needed.
2. A listing of the current business associate relationships, including the scope of work and types of allowed disclosures of PHI will be maintained at the administrative office and will be available to all department heads and to each site's officer manager or administrative manager.
    a. The list will be updated as needed.
3. All business associate agreements will follow basically the form of the contract attached and will be approved by the agency's counsel, Privacy Officer and CEO.
    a. No business associate agreement can be modified or changed without the approval of the agency's counsel and the Privacy Officer.
    b. Copies of executed Business Associate Agreements will be maintained by the agency's finance department.
4. If at any time, any staff person becomes aware that a business associate is in breach of their business associate agreement, he/she should contact their supervisor or the Privacy Officer directly. These breaches can include security lapses, privacy violations, and, in addition, non-cooperation with the agency in complying with its obligations, for example, to account for disclosures of PHI or to give individuals access to their PHI.
    a. Business Associates as a part of their contract with Davis Behavioral Health are required to report any breaches of our contract with them or violations of our

privacy practices. Any reports received from a Business Associate should be immediately forwarded to the Privacy Officer.

b. The Privacy Officer will be responsible for logging these reports and for follow-up.

c. If the Privacy Officer believes that the business associate has materially breached the agreement or has been reported a number of times for smaller breaches such that the Privacy Officer is concerned about the business associate's ability to perform in compliance with the agreement, the Privacy Officer can, after consultation with agency's counsel, terminate the entire contractual relationship with the business associate.

5. Upon termination of a business associate agreement, the business associate must destroy or return the PHI they are maintaining, using or storing on behalf of the agency. The Privacy Officer or his designee will be responsible for overseeing the orderly transfer or destruction of the PHI and for assuring the business associate's compliance with any post-contract obligations. If the PHI cannot be returned or destroyed, the Privacy Officer should extend the protections of the Business Associate Agreement to the PHI still being held and limit further use and disclosure to those purposes only that prevent the return or destruction of the PHI.

Policy 6 The Designated Record Set and PHI

Procedures

1. Every client will have a medical record, which includes financial information for billing purposes that together will comprise the "designated record set" for the client.
2. If an employee or contactor of Davis Behavioral Health is not sure if a certain document or piece of information belongs in the designated record set, he/she should contact his/her supervisor or the Privacy Officer for advice.
3. If an employee or contractor believes that there are documents in a client's designated record set that do not belong there, he/she should contact their supervisor or the Privacy Officer for advice on how to proceed.
4. Medical Records:

a. The medical record will be created, stored, and secured according to agency policy and licensing requirements. It will contain, at least, the following information:

    1) The clinical diagnostic assessment
    2) The psychiatric diagnostic assessment
    3) The treatment plan
    4) Consents for treatment
    5) Reports from indirect treatment providers
    6) Functional status assessments
    7) Medication profiles
    8) Progress notes and documentation of care provided (for both treatment and reimbursement purposes)
    9) Multidisciplinary progress notes/documentation
    10) Content of any consultation with internal or external individuals regarding the client's care
    11) Nursing assessments
    12) Orders for diagnostic tests and diagnostic study results
    13) Practice guidelines that imbed patient data
    14) Records of physical history and examinations
    15) Respiratory therapy, physical therapy, speech therapy, occupational therapy records, and any other records of services provided by specialty providers
    16) Telephone consultation records
    17) Telephone orders

18) Discharge instructions
19) Legal documents and correspondence between the agency and the client or others involved in the client's care
20) Utilization management or utilization review forms that are used to determine or review level of care decisions including admission, continuing stay, and discharge

b. All of the information in the medical record that is used to make decisions about the individual will be a part of the designated record set.

c. Employees and contractors, who create or handle the PHI that will become a part of the medical record or who have access to the medical record have certain responsibilities. These responsibilities include:

1) All PHI created by an employee or contractor of agency should comply with agency policy and regulation on content, dating, and appropriate signatures.
2) All PHI required to be created by an employee or contractor should be completed as soon as possible and at least within the time frames designated by agency policy on medical records or other applicable policy.
3) Any PHI obtained from a third party by an employee or contractor that should be filed in the medical record should be reviewed as soon as possible for relevant content and placed in the appropriate place to be filed in the medical record or should be filed by the employee or contractor who received the third party PHI.
4) Any PHI that must be filed in the medical record should be filed on a timely basis, in date order, and in the appropriate section of the medical record.
5) Clinical staff who wish to create, use, and store Psychotherapy Notes (as defined by HIPAA Privacy Rule) must have the prior approval of the Privacy Officer before doing so. These Notes are **not** a part of the medical record and should not be kept in the medical record. They are not a part of the designated record set.
6) Clinical or direct service staff who wish to create a supplementary client record for their use in the community or at satellite sites that includes copies of any part of the medical record or any other PHI must obtain the prior approval of the Privacy Officer.

5. Billing Records

a. The billing record will be created, stored, and secured according to agency policy and licensing requirements. It will contain, at least, the following information:

1) Signature on file
2) Consent to bill third parties
3) Individual Financial Hardship Assessment (i.e., Income Affidavit)

4) Copies of any insurance cards and other data on insurance coverage
5) Fee Agreement
6) Requests for prior authorization of services
7) Authorizations for services or other written acknowledgements of client eligibility for services
8) Billing records including dates, services provided, provider, billing and payment records, and other information used to bill or to record and report encounters or services.

b. The responsibility for maintaining the billing record is shared by a number of departments in the agency. This includes clinical and support services who often first hear from clients about changes in insurance or financial status and are responsible for completing certain documents in the billing record such as requests for service authorizations.

c. Each employee or contractor who is responsible for obtaining or maintaining any of the billing records is responsible for:
   1) Ensuring that the information is complete, communicated to the appropriate person, and filed (or entered into the billing database) in a timely manner.
   2) Ensuring that the information is appropriately secured according to agency policy.

d. No employee or contractor should maintain any of the information contained in the billing record in a separate file or outside of the locations designated in agency policy. However, in certain circumstances, an employee may be asked to obtain billing information in a community location or at a satellite site. In these cases, the information should be secured until it can be given or communicated to the appropriate person.

Policy 7 Privacy Notice

Procedures

1. The Privacy Officer, in consultation with agency's counsel, will develop the Privacy Notice. The Privacy Officer may request that an ad hoc committee of employees be appointed to assist in this effort.

   a. The ELT must approve the Privacy Notice.
   b. The Privacy Notice in effect at any time will be the notice attached to this policy.
   c. When necessary, an ad hoc committee facilitated by the Privacy Officer will be constituted to review the current version of the Privacy Notice and to suggest modifications to the ELT.

2. All staff members of the agency are responsible for reading and understanding the Privacy Notice and the practices and procedures the agency must follow in order to comply with the practices described in the Privacy Notice.

   a. Any employee who believes that the agency is not complying with its Privacy Notice or is concerned about any behaviors or actions of any employees, independent contractors, or business associates with regard to consumer privacy and the Privacy Notice must report those concerns either to their supervisor, directly to the Privacy Officer/ Compliance Officer of the organization.
   b. All employees will be trained on the privacy practices of the agency, including all practices outlined in the Privacy Notice.
      1) New employees will have training on the privacy practices of the agency incorporated into their orientation programs.
      2) Current employees will receive training in conjunction with the agency's training on the Privacy Regulations that is required under HIPAA.
      3) If and when the Privacy Notice is modified, all employees will receive notice of any changes, a description of any operational changes that must be implemented in order to comply with the changes to the Privacy Notice and information on how their day-to-day work will change as a result.

3. The Privacy Notice will be clearly and prominently displayed in a public area at every site in the agency including all administrative sites. At all service delivery sites, the notice will be displayed, at a minimum, in the clients' waiting room.

a. Paper copies of the Privacy Notice will be kept at every site and will be available to any consumer or consumer representative who requests one. Consumers can also ask that copies of the Notice be mailed or e-mailed to them.

b. Each new consumer must be given the opportunity to review the Privacy Notice prior to receiving any services from us.

1) For facility based clinic clients, administrative staff (i.e., enrollment specialist) will be responsible for ensuring that all new clients are given a copy of the notice and for requesting that they acknowledge their receipt of the Notice on the clients' rights form.
2) Residential clients will be given a copy of the notice, prior to their initial intake by a designated staff person. The administrative staff will be responsible for ensuring that residential clients are given a copy of the notice and for requesting that they acknowledge their receipt of the Notice on the clients' rights form..
3) Community-based clients will be given a copy of the Notice by the intake clinician who will request their written acknowledgment.
4) In emergency situations, a copy of the notice should be given to the client and written acknowledgment requested as soon as it is safe to do so without interfering with treatment.
5) If a client does not sign the written acknowledgement of their receipt of the Privacy Notice, the designated staff person should discuss their reasons for not signing and should document both the effort to get the written acknowledgment and the reason for not obtaining it on the consent to treat form. This note should be dated and signed.

c. The Privacy Notice is written in plain language in order to make sure that consumers of our services understand our privacy practices. The notice is also "layered" and contains a two-page summary of our privacy practices or an 11-page version with substantial detail. The consumer is offered the two-page version, however the 11-page version is available upon request. Additionally, it is up to the intake staff persons at each site and program to determine if the consumer can understand the English language written notice or if a different method of informing the consumer about the agency's privacy practices needs to be considered. For those reasons, the agency will offer consumers the following alternatives:

1) Consumers, who cannot read and comprehend the Privacy Notice as written, should be offered the opportunity to have the Notice read to them by a staff person.
   i. Each site must have a plan in place that designates who will be responsible for reading the Privacy Notice to clients who need this service.
   ii. Alternatively the client may have a relative or friend, who accompanied them to the visit, be able to read the Notice to the consumer.
   iii. For consumers under the age of 18, the Privacy Notice will be offered to the parent or any other custodian who is responsible for consenting to their medical care.
2) Alternative Languages – the Privacy Notice will be available in Spanish.

4. Consumer questions about the Privacy Notice should be answered promptly and completely. If a staff person is unable to answer a question, the consumer should be directed to the Privacy Officer for additional information. If the consumer wishes to contact the Privacy Officer, he/she should be given a copy of the Privacy Notice which has the Privacy Officer's name and contact information on it.

5. The Privacy Notice allows the agency to modify or change its Privacy Practices, but clients must be given appropriate notice of the planned changes.

a. Each version of the Privacy Notice will have an effective date printed on each page.
b. Copies of the revised Notices will be sent to the Office Manager or Unit Manager at each site, including the administrative offices, at least 15 days prior to the effective date of the new Notice.
c. The staff person receiving the notice is responsible for ensuring that all old copies of the Notice are destroyed and that the new Notice is in place within 48 hours of receipt of the notice. In order to make sure that community-based clinicians, satellite sites, and other outreach sites have the appropriate copies of the Notice, each Unit Manager/Office Manager must have a site-based procedure in place to ensure that the appropriate distribution of the new notice and destruction of the old notice takes place.
d. Copies of the new version of the Privacy Notice will be made available to clients upon request at least 10 days before the effective date.
e. All Business Associates must receive a copy of the revised Notice at least 10 days before the effective date.

6. The agency's website will have on its home page a link to the agency's Privacy Notice that is prominently displayed.
    a. Updates and revisions to the notice must be placed on the website within the time frames described in 5 a. - c. above.
    b. The responsibility for placing the Notice and any revisions on the agency's website belongs to the agency's designated webmaster.

Policy 8 Minimum Necessary

Procedures

Staff Access to PHI Using the Minimum Necessary Standard

1. The Privacy Officer in consultation with Agency's clinical staff will develop the Role-based Access to PHI Matrix ("Access Matrix"). This Access Matrix should be reviewed by counsel prior to implementation. The Privacy Officer may request that an ad hoc committee of employees be appointed to assist in this effort.
    a. The ELT must approve the initial Access Matrix.
    b. The Access Matrix in effect at any time will be the matrix attached to this proceedure.
    c. When necessary, an ad hoc committee, facilitated by the Privacy Officer or his designee will be constituted to review the current version of the Access Matrix and to suggest modifications to the ELT.
2. All staff members of the agency are responsible for reviewing the Access Matrix and for understanding how it impacts their role within the agency.
    a. Any employee, who believes that any employee or department within the agency is not complying with the Access Matrix, must report those concerns either to their supervisor, directly to the Privacy Officer/Compliance Officer of the organization.
    b. All employees will be trained on the Access Matrix and all supervisors in the agency will be prepared to assist their supervisees in complying with its limitations on access to PHI.
        i. New employees will have training on the Access Matrix incorporated into their orientation programs.
        ii. Current employees will receive training in conjunction with the agency's training on the Privacy Regulations that is required under HIPAA.
        iii. If and when the Access Matrix is modified, all employees will receive notice of any changes, a description of any operational changes that must be implemented in order to comply with the changes to the Access Matrix, and information on how their day-to-day work will change as a result.
        iv. The Director of Human Resources will be advised in advance of any changes in order to incorporate them into training curricula.
3. The Access Matrix currently in effect will be attached to this procedure and may have an effective date later than this procedure. Staff can make copies of the Access Matrix to

assist them in complying with its requirements. All unit managers and office managers of both clinical and administrative sites are expected to have a current copy of the Access Matrix available to assist them in their supervisory and oversight activities.

4. The Access Matrix lists the various positions or roles within the agency, the types of activities undertaken by the role that use PHI, and the types of PHI that are needed by staff persons in those roles to fulfill their job requirements.
    a. This list is developed using a standard of only allowing access to the minimum amount of PHI that is necessary for the use of PHI. In some cases, it is not reasonable to limit the PHI to the minimum necessary. For example, if information that is needed by a staff person is contained in a paper medical record, he/she will need access to the whole record. We do not expect that the records will be kept in pieces with staff persons only allowed access to some pieces and not others. We do expect, however, that staff persons who routinely need information that is located in one section of the record will only go to that section of the record, retrieve the needed information, and not access, review, copy, or retrieve information from other parts of the record. The same behaviors should now govern access by staff to PHI or their use of PHI.
    b. If a staff person believes that in a non-routine situation or on a permanent basis he/she needs to access PHI that is not listed for him/her on the Access Matrix, he/she should appeal to the Privacy Officer.
        i. The Privacy Officer can override the matrix for a single, non-routine situation. The Privacy Officer should document, in writing, the reason for the override, the situations and persons to which it will apply, and the applicable dates.
        ii. The Privacy Officer cannot make any modifications to the Access Matrix without the approval of the ELT.
        iii. If a staff person is not sure if he/she can have access to certain PHI, he/she should first consult their supervisor. If the supervisor is unable to answer the staff person's question, the supervisor should go directly to the Privacy Officer for advice on the matter.
    c. Staff persons who do not comply with the Access Matrix are subject to disciplinary sanctions up to and including termination.

Disclosures

Disclosures of PHI are categorized by the Privacy Regulations as follows:

a. Disclosures that are not required to meet the minimum necessary requirements
b. Disclosures that are required to meet the minimum necessary requirements, and within this category
    i. Routine and Recurring Disclosures
    ii. Non-routine and Non-recurring Disclosures

Disclosures that are not required to meet the minimum necessary standard

1. Disclosures of PHI to the client are not subject to the minimum necessary requirement.

2. Disclosures of PHI to health care providers for treatment purposes are not subject to the minimum necessary requirement. This allows staff to determine quickly and without constraint the information that is necessary for the members to know in order to care for the client. However, please see Policy 1: Uses and Disclosures for Treatment, Payment and Operations for restrictions on disclosures to third party members of the treatment team.

Please see the Authorizations Policy for additional information on disclosing mental health, substance abuse, and HIV/AIDS information to treatment team members.

3. Disclosures of PHI that are being done in response to an authorization (including a client initiated authorization) are, in most cases, not subject to the minimum necessary requirements. The exceptions to this are:
    a. Authorizations that we are requesting. We are required to apply the minimum necessary standards to our requests for disclosures to us by third parties. By signing the authorization, the client consents to our determination of the minimum necessary.
    b. Authorizations sent by third parties to us where we believe the authorization is excessive or is not warranted. For example, a client requests the disclosure of their psychotherapy notes to his/her employer. In those cases, the staff person who receives the authorization should consult with their supervisor or the Privacy Officer to determine if the client should be contacted and wishes to submit a modified authorization.

Please see the Authorizations Policy for instructions on the requirements for a valid authorization.

4. Disclosures of PHI to the Department of Health and Human Services for compliance purposes and disclosures that we are required to make in order to comply with the HIPAA regulations on standard transactions are not subject to the minimum necessary requirements.
    a. Many of these disclosures will be made routinely, for example, PHI contained in a bill for services and are covered by other policies and procedures in the agency.
    b. If a staff person, however, gets any request for PHI from a person(s) purporting to be a representative of Department of Health and Human Services or any of its sub-agencies, he/she should contact their supervisor, ELT member, or the Privacy Officer about the request before disclosing any information.
        i. If the Privacy Officer is not available, legal counsel should be contacted.
        ii. If the person representing the Department of Health and Human Services presents in person at a site and states that he/she is involved in an investigation, audit, or any other type of fact-finding mission, staff should confirm their credentials, but should not interfere with the investigation or audit process.
5. Disclosures that we are required to make by law. In this case, we are only permitted to release the information that is relevant to the requirements of the law.

Please see the Authorizations policy for additional information on disclosures required by law.

Routine and Recurring Disclosures

1. The Privacy Officer in consultation with Agency's counsel will develop the Routine Disclosures Matrix ("Disclosures Matrix"). The Privacy Officer may request that an ad hoc committee of employees be appointed to assist in this effort.
    a. The ELT must approve the initialDisclosures Matrix.
    b. The Disclosures Matrix in effect at any time will be the matrix attached to this procedure.
    c. When necessary, an ad hoc committee facilitated by the Privacy Officer or his designee will be constituted to review the current version of the Disclosures Matrix and to suggest modifications to the ELT.

2. All staff members of the Agency are responsible for reviewing the Disclosures Matrix and for understanding how it affects disclosures of PHI they may be asked to make.
    a. Any employee, who believes that an employee or department within the agency is not complying with the Disclosures Matrix, must report those concerns either to their supervisor, directly to the Privacy Officer/Compliance Officer of the organization.
    b. All employees will be trained on the Disclosures Matrix, and all supervisors in the agency will be prepared to assist their supervisees in complying with its requirements.
        i. New employees will have training on the Disclosures Matrix incorporated into their orientation programs.
        ii. Current employees will receive training in conjunction with the agency's training on the Privacy Regulations that is required under HIPAA.
        iii. If and when the Disclosures Matrix is modified, all employees will receive notice of any changes, a description of any operational changes that must be implemented in order to comply with the changes to the Disclosures Matrix and information on how their day-to-day work will change as a result, if at all.
        iv. The Director of Human Resources will be advised in advance of any changes in order to incorporate them into training curricula.
3. The Disclosures Matrix currently in effect will be attached to this policy and procedure. Staff can make copies of the Disclosures Matrix to assist them in complying with its requirements. All unit managers and office managers of both clinical and administrative sites are expected to have a current copy of the Disclosures Matrix available to assist them in their supervisory and oversight activities.
4. The Disclosures Matrix lists routine disclosures by type, (i.e., "Disclosures for eligibility determinations for Social Security benefits"), the roles or positions of the persons that the PHI should be disclosed to, and, the types of PHI that can be disclosed.
    a. This list is developed using a standard of only allowing access to the minimum amount of PHI that is necessary for the use or disclosure of PHI. In some cases, it is not reasonable to limit the PHI to the minimum necessary. For example, in some cases, especially with paper records, it may not be possible to separate information out or may not be reasonable to redact every piece of information that is not needed for the purpose of the disclosure. Any staff person,

who believes that compliance with the Disclosures Matrix in a particular case violates the minimum necessary standard, should appeal to their supervisor. The supervisor may then appeal to the Privacy Officer for assistance.

b. The Privacy Rule exempts from the minimum necessary standard all required elements of the HIPAA electronic transactions, however, the optional elements of these transactions must be considered in developing the Disclosures Matrix.

c. Any type of disclosure not listed as a routine disclosure on the Disclosure Matrix is considered a non-routine disclosure, and staff must follow the procedures listed below under non-routine disclosures.

d. All disclosures of the entire medical record to a third party for payment or for operations pursuant to Policy 1: Uses and Disclosures for Treatment, Payment and Operations are considered non-routine disclosures. See also below, "Disclosure of the Entire Medical Record".

e. The Privacy Officer cannot make any modifications to the Access Matrix without the approval of ELT.

f. If a staff person is not sure if a particular disclosure meets the definition of a routine disclosure, he/she should first consult their supervisor. If the supervisor is unable to make the determination, he/she should go directly to the Privacy Officer for advice on the matter.

g. Staff persons who do not comply with the Disclosures Matrix are subject to disciplinary sanctions up to and including termination.

Non-Routine and Non-recurring Disclosures

1. Non-routine and non-recurring disclosures are any disclosures that are subject to the minimum necessary standard and are not listed on the Disclosures Matrix as a routine and recurring disclosure. Please see above "Disclosures that are not required to meet the minimum necessary standard" and "Routine Disclosures".
2. Davis Behavioral Health will designate at least one licensed clinical professional at each site to be expert resources for agency staff on non-routine disclosures. This includes administrative as well as clinical delivery sites.
    a. These Disclosure Experts will be trained on agency policy and regulation concerning the non-routine disclosures of PHI.

b. These staff persons will be responsible for reviewing all requests for the non-routine disclosures of PHI and determining which PHI should be disclosed in order for the agency to meet the minimum necessary standard.

3. All staff persons requesting a review of non-routine disclosures should have the following information available for the reviewer:
   a. The authorization or request if in writing.
   b. The staff person's assessment of the PHI that should be disclosed and why.
   c. Any back-up documentation, for example, the medical record, which can assist the reviewer in making the determination.
4. The Disclosure Experts and all agency staff can, but are not required to, rely that, in the following cases, the PHI being requested is the minimum necessary as follows:
   a. Requests by:
      i. Public officials for a disclosure not requiring any legal permission if the public official represents that the information requested is the minimum necessary;
      ii. Other covered entities;
      iii. A professional who is either a member of our workforce or a business associate and the request is for the purpose of providing professional services to Davis Behavioral Health and the professional has asserted that the PHI requested is the minimum necessary for their stated purpose;
      iv. Payers for the purposes of conducting the HIPAA standard transactions including all required elements of those transactions. The optional elements are subject to the minimum necessary standard and will be dealt with as a routine or non-routine disclosure as described above; and
      v. Researchers as long as we have received documentation from an IRB or privacy board and we have determined the PHI that minimally necessary to achieve the scope of the use or disclosure.
   b. If a staff person, for any reason, believes that the requestor should not be relied upon to determine the minimum necessary PHI they need and have listed on the request, he/she should make sure the Disclosure Expert is advised of their opinion so they may include this information in their deliberation.
   c. The decision by the Disclosure Expert should be documented on the document requesting the PHI or linked or attached to the document. The decision should be signed and dated.

Disclosing the Entire Medical Record

Each time a disclosure of PHI is made that includes the entire medical record, the decision to disclose the entire record must be documented, including the reasons why, and placed in the medical record attached to the written request (if one is available). A copy of the documentation should be sent to the Privacy Officer.

If a written request is not available, the documentation should include the requestor's name, position, and agency or company, the stated reason for the request, the date, and the signature and name of the person making the disclosure.

This does not apply to disclosures made for treatment purposes, to a client, or pursuant to a client's authorization.

Policy 9 De-identification and Limited Data Sets

Procedures

1. With the exception of treatment and payment information where the identity of the individual is critical, each time PHI is used or disclosed by Davis Behavioral Health, the person handling the PHI should consider whether the PHI could reasonably be de-identified and still be used for the purpose of the disclosure or whether or not a limited data set might substitute for the PHI requested.. There are, for example, some Quality Improvement operations where de-identified data can be as useful as data that is individually identifiable. Also some reports to outside payers or funders could contain de-identified information and comply with our contractual requirements. The process of considering whether or not the information could be reasonably de-identified or could be disclosed in a limited data set is in keeping with our minimum necessary policy and should consider the cost/benefit of the de-identification procedure. Please see Policy for the Minimum Necessary standards.
2. Staff persons disclosing PHI for internal or external purposes should:
    a. Determine if the PHI should be de-identified or disclosed only as a limited data set prior to its disclosure either internally or externally. See above re: minimum necessary.
    b. If the PHI is to be de-identified, determine if it can reasonably be de-identified in one of two ways:
        i. Removal of all identifying elements listed in the policy above.
        ii. Engagement of a qualified statistician to determine if the PHI, alone or in combination with other reasonably available information, could be used by the recipient to identify the individual.
    c. If the PHI will be disclosed only as a limited data set, determine how best to remove the required identifying information listed in the policy above.
    d. If b.i. or c. above is determined to be a reasonable course of action, the staff person should remove the identifying elements or direct that they be removed. The person responsible for the disclosure will be held accountable for the content of the disclosure. Any staff person delegating the task of de-identification or the creation of a limited data set to another staff person should carefully review the results of this work before releasing the information.

e. If b.ii. above is determined to be the only reasonable course of action, the staff person must contact the Privacy Officer who will be responsible for determining if the qualified statistician should be engaged and for managing the engagement.

f. If c. above is chosen and the information will be released as a limited data set, the staff person responsible for the disclosure must ensure that a "data use agreement" is negotiated and signed before the disclosure is made. The data use agreements must be developed in conjunction with and approved by the Privacy Officer and the organization's legal counsel. See policy above for required elements of a data use agreement. If any staff person becomes aware that the recipients of a limited data set are in breach of the agreement, they must notify the Privacy Officer at once. The Privacy Officer will ensure that immediate steps are taken to cease further disclosures and will report the breach to the Secretary of Health and Human Services.

g. If either b.i. or ii. or c. is chosen, Davis Behavioral Health may wish to develop a key that would allow the information to be re-identified. This re-identification code may not be derived from or related to information about the individual(s) and may not be otherwise translatable to identify the individual(s). The code will not be disclosed nor the means for re-identification for any purpose.

    i. The staff person responsible for the disclosure should document the de-identification process and the key for re-identifying the information and keep a copy in the file that contains a copy of the de-identified PHI disclosed. This file must be secured according to Agency procedures for securing PHI not held in the designated record set.

    ii. If an outside statistician is involved in the de-identification, including development or evaluation of the re-identification key, their contract with Davis Behavioral Health will specify their obligations with regards to the privacy and security of the PHI they must use to complete their work. The Privacy Officer or a designee will be responsible for monitoring the work of the statistician and for maintaining all documentation including any re-identification keys as described above in g.i.

Policy 10 Individual's Right to Access

Procedures

1. The initial determination about whether or not a consumer should be granted or denied access to PHI in their designated record set (see Policy 6, Designated Record Set) within Davis Behavioral Health can only be made by a licensed professional. The Privacy Officer will be responsible for designating one or more licensed health care professionals in each instance who will be responsible for making decisions about client access to records in those cases where the primary direct care provider is not a licensed individual. The Privacy Officer will train all licensed professionals on staff on the agency's policy and procedures with regard to consumer access to PHI.
2. The Privacy Notice, which is available to every Agency client, provides information on client rights to access PHI, the procedures they must follow to request access, and the procedures available to them should there be a partial or a complete denial of their request to access PHI.
3. Each request by a client or a client's personal representative for access to PHI contained in the agency's designated record sets must be made in writing. Clients will be asked to direct their requests to their primary direct care provider. The procedures that will be followed by those receiving the requests are outlined below:

   The agency only has **thirty days** to act on the request for access. The person receiving the request may or may not be the person who will be responsible for acting on the request. It is very important that any staff person who receives a request review it quickly to determine if they should coordinate the Agency's response or the request should be directed to someone else. If it needs to be directed to the Privacy Officer, it should be placed in the internal mail system as soon as possible.
4. Access to Medical Records
   a. For requests by clients to access information in the medical record portion of the designated record set, see procedure below and flow chart labeled "Procedure for Approving/Denying Client Access to PHI in the Medical Record Only" below:
      i. The primary direct care provider, if licensed, is responsible for coordinating and directing the decision-making process on the request and for coordinating the actual physical or electronic access by the consumer to their PHI in the designated record set portions of the medical record. This may include involving the treatment team in the decision-making process.

ii. If the primary direct care provider is not a licensed professional, the request should be given to the individual's supervisor to coordinate and act on the request.

iii. If there is no primary direct care provider because the consumer is not currently a client of the agency, the request should be given to the past therapist, supervisor, or Privacy Officer to coordinate and act on the request. If this determination cannot be made, the request should go to the Privacy Officer who will handle the request or delegate it to another appropriate staff person.

iv. If the individual responsible for coordinating the effort believes that the request cannot be handled within the 30 day time period for on-site records or the 60 day time period for off-site records, he/she is responsible for contacting the client in writing to inform him/her of the one time, 30 day delay, the reason for the delay, and when the consumer can expect to see their records. This correspondence should be stapled to the original request and filed in the medical record when all activities related to the request are completed.

v. If any staff person designated as the responsible party for acting on the request needs technical assistance or consultation, he/she should contact the Privacy Officer.

b. The person responsible for coordinating the agency's response, either the primary provider or supervisor, may consult or meet with the team of internal providers assigned to the consumer and, therefore, authors of the consumer's medical record. The team will approve or disapprove the consumer's request.

c. A list of reviewable and non-reviewable reasons for not approving the consumer's request can be found in the policy above.

d. If the request is approved, the person responsible for coordinating the agency's response will contact the consumer, determine how he/she prefers to have access (in person, copies of documents, or a summary) and will either act on it directly or delegate the responsibility to another staff person. The person responsible for coordinating the agency's response is responsible (whether or not any of the activities are delegated to another staff person) for ensuring the consumer has the access he/she requested and is satisfied with the agency's actions.

e. All documentation relating to the request and the agency's actions should be maintained in the medical record.

Access to Billing Records

f. For requests by consumers to access information in the billing records of the designated record set, see procedure below and also see flow chart below labeled, "Procedure for Approving/Denying Consumer Access to PHI in the Billing Records"
    i. All requests should be directed to the Office Manager, Unit Manager, or Accounts Receivable Department who will review the request with the Accounts Receivable Supervisor or CFO.
    ii. The Accounts Receivable Supervisor will determine if the request should be denied or approved. If the request is partially denied, the Privacy Officer must be informed and must approve the denial..
    iii. If the consumer is not an active consumer with an open record, the request should be given to the Accounts Receivable Supervisor to coordinate and act on the request.
    iv. If the individual responsible for coordinating the effort believes that the request cannot be handled within the 30 day time period for on-site records or the 60 day time period for off-site records, he/she is responsible for contacting the client in writing to inform him/her of the one time, 30 day delay, the reason for the delay, and when the consumer can expect to see his/her records. This correspondence should be stapled to the original request and filed as described in b. below when all activities related to the request have been completed.
    v. If any staff person designated as the responsible party for acting on the request needs technical assistance or consultation, he/she should contact the Privacy Officer.
g. All requests and any actions taken should be filed in the medical record.

5. If the request by the consumer to access the PHI in the designated record set is approved, and the information is contained in more than one place, Davis Behavioral Health is required only to give the consumer access to it in one place, not all locations. It will be the responsibility of the Privacy Officer to determine the PHI to which the consumer will be given access. The decision should be guided by the agency's policy to give free and open access to consumers of their health information, including information that is in the form that will be most easily understood by the consumer.
6. If the consumer requests a copy or a summary of their PHI, the person responsible for coordinating the agency's response will:
    a. Ask the Finance Department for the current charges for copying pages of the medical record or other PHI in the designated record set,
    b. Determine with the client the media format in which they wish to receive their copy. If there is no agreement between us and the client as to the media format, then we will produce a readable hardcopy of the PHI requested or any other format that is reasonable for us to produce, and,
    c. Contact the Privacy Officer to discuss the charges that should be made for a summary of the PHI requested. In lieu of a discussion, the agency may post an hourly charge for this work.
        i. In all cases the consumer must be informed ahead of time of the charge for the summary.
        ii. Charges must be paid prior to the release of the summary to the consumer.
7. If a consumer has their request for access denied partially or in whole and the decision is one which falls into the reviewable category (see Policy 10), then:
    a. The consumer will be told in a denial letter that the denial falls into the reviewable category, that a request for review of the decision must be made in writing and directed to the Privacy Officer.
    b. The Privacy Officer will coordinate a review of the Request, the PHI in question, and the decision to deny by a licensed health care professional who was not a part of the original denial decision.
        i. Barring any conflict, the Privacy Officer, an ELTRepresentative, or the Medical Director of the agency should complete this review.
        ii. If the decision is upheld, the reviewer will inform the consumer in writing. This letter will also contain information on how the consumer may complain

about this decision through the Davis Behavioral Health complaint process and to the Secretary of Health and Human Services.

iii. If the decision to deny is overturned, the original person responsible for coordinating the agency's effort will be responsible for informing the consumer and coordinating the consumer's access to their PHI.

8. If a consumer has his/her request for access denied partially or in whole and the decision is one which falls into the non-reviewable category (see Policy 10), then:
    a. The consumer will be informed in a denial letter of the non-reviewable nature of the denial and will be instructed on how to complain to the Secretary of Health and Human Services if they so choose.
    b. If the denial is a partial denial, the person responsible for coordinating the agency's response will contact the consumer and coordinate their access to the PHI that they will be allowed to access.

Policy 11 Individual's Right to Amendment of PHI

Procedures

1. Individual clients who wish to amend any of the PHI held by Davis Behavioral Health should be directed to make the request in writing using the Request for Amendment form attached to Policy 11.
    a. If necessary, the individual client should be assisted by agency employees in completing the form.
    b. Clients should be directed to send all completed forms via the United States Post Office, other private mail delivery system, or hand delivery to the address of the Privacy Officer.
        i. Under no circumstances should staff offer to use the internal mail system to deliver these completed forms.
        ii. If a staff person receives a completed form in error, he/she should reseal the form and place it in internal mail to be delivered to the Privacy Officer or should place the form in a new envelope and mail it directly to the correct address.

2. The Privacy Officer should log all Request for Amendment forms into a database that includes the date of the request, the date received, name of client, and primary provider.

3. The Privacy Officer should then contact the current primary provider and notify him/her of the request and the content of the request.
    a. The Privacy Officer should, in discussion with the primary provider determine:
        i. Who should be involved in the decision about the amendment (i.e., the clinical supervisor, the ELT representative, agencycounsel, CEO, etc.).
        ii. A reasonable time frame for requesting that the above individuals give their input as to whether or not the amendment should be approved or denied.
        iii. The above decisions should be based on the significance of the amendment being requested, the use of the PHI both internally and externally, and the impact of the amendment on the client. For example, a simple change in a relatively insignificant date may be able to be approved easily with very little input from others besides the primary provider and the Privacy Officer. A

change in a diagnosis, however, may require the input of all internal providers, certain business associates, and others who have relied on or have used the information to guide their care of the client.

iv. In all cases, the preliminary input should be received no later than 30 days from the date of the request, if possible, to allow for additional discussion and input where there is disagreement.

b. The Privacy Officer could appoint the members of a clinical review team for that client, inform the team of the request, discuss the contents of the request, and identify the date for returning preliminary input to the Privacy Officer.

c. The Privacy Officer should, with the primary provider, review the responses of the clinical review team members to determine if there is a consensus on whether or not to approve the amendment.

   i. The amendment can be denied for the following reasons:

      a. The record is already accurate and complete;

      b. The information was not created by Davis Behavioral Health, and the original source is not available to make the correction;

      c. The information is not a part of the designated record set.

      d. The PHI that is the subject of the proposed amendment is not available to the individual because access is not permitted or has been denied under § 164.524 of the HIPAA Privacy Regulations. See Policy 10-Access.

   ii. If there is disagreement among the clinical review team members, the Privacy Officer should set up a meeting or conference call to try to reach consensus. The Medical Director and/or ELT representatives should attend this meeting.

   iii. If at the meeting consensus cannot be reached, the Privacy Officer, in consultation with the Medical Director and/or Agency Counsel, will make the final decision using the input from all clinical review team members.

   iv. If it appears that the decision cannot be made within the 60-day period required, the Privacy Officer will inform the client of the need for a one-time 30-day extension. This notification will be made in writing, in plain language, will explain why the decision will be delayed, and will give the client the date he/she can expect a decision.

d. The Privacy Officer will inform the client of the decision.

   i. This reply will be in plain language and it will be in writing.

ii. If the amendment is approved, the Privacy Officer will:

a. Determine with the clinical review team, how and what records are affected by the amendment and should be corrected. This includes the records of any business associates who have and/or use the amended PHI.

b. Direct appropriate staff to make the corrections by either attaching the amended information directly to the PHI being amended or by creating a link to the amended information from the original information. In all cases, both the amended and original information will be sent together for any future disclosures of this PHI either internally or externally.

c. Direct the primary provider to discuss with client and develop a list of who should be informed of the amendment and obtain written agreement of the client to do so.

d. Both the client and the primary provider should sign the bottom of the list as in indication that the client has agreed with the list.

e. Direct appropriate staff to make reasonable efforts to locate and inform those on the agreed-upon list (in c. above) of the amendment. The staff should make sure that written confirmation, including a copy of the amendment, is sent to all persons on the list who could be located. If Davis Behavioral Health is unable to locate any person, a notation should be made on the Request for Amendment form. (Reasonable efforts include the following steps: (1) request that the client provide Davis Behavioral Health with the most recent contact information for each individual and/or entity on the list; (2) confirm the contact information via telephone; (3) mail a written copy of the amendment to the confirmed addresses [amendment information cannot be delivered orally nor should it be mailed to non-confirmed addresses]; (4) if the address cannot be confirmed, notify the client and do not send the amendment; and (5) document that Davis Behavioral Health has notified the client that contact information could not be confirmed by noting on the list next to the name of the individual or entity “client notified that address could not be confirmed” and the date. Davis Behavioral Health staff member is to initial the note.

f. Inform the client in writing of all actions taken.

iii. If the amendment is not approved, the Privacy Officer will include in the notice of denial the following information:

a. The basis for the denial;

b. The client's right to file a written statement disagreeing withthe denial. The client should be directed to send the statement to the Privacy Officer at the address included in the notice of denial;

c. The process for the client to use to file a complaint about the denial, including the name, title, and telephone number of the person or office responsible for complaints; and

d. The process for filing a complaint with the Secretary of the Department of Health and Human Services.

4. If the client files a written statement of disagreement with the denial of their amendment request, the Privacy Officer will consult with both the client's primary provider and the Medical Director or ELT representative to determine if the agencywishes to create a rebuttal statement to the written statement of disagreement.
    a. If the agency decides not to file a rebuttal statement, a copy of the request, denial, and statement of disagreement should be attached to the PHI the client asked to be amended and all included in any future disclosures of this PHI.
    b. If the agency decides that it will file a rebuttal statement, this statement along with the request, denial, and statement of disagreement will be included together in any future disclosures of this PHI and a copy of the rebuttal statement will also be mailed to the client.

5. The Privacy Officer will be responsible for setting up a meeting with the client and either the Medical Director or the ELT representative to discuss their disagreement with the denial.
    a. The Medical Director or ELT representative will then meetseparately with the clinical review team to discuss their reasons for denying the amendment.
    b. The Medical or ELT representative will then send a writtennotice to the client and to the members of the clinical review team of the final decision.

c. The notice to the client will include information on the process for filing a complaint with the Secretary of the Department of Health and Human Services, if the decision to deny the amendment is upheld. See Policy 16, Complaints.

Procedure for Amending PHI Held in the Designated Record Set that was Created by Another Covered Entity, Health Care Provider or Other Third Party

1. If any staff person receives a notice of amendment of PHI by another Covered Entity or provider, he/she should send the notice directly to the Privacy Officer.
2. The Privacy Officer, in consultation with the primary provider, the medical records director, and/or the billing director will determine in which record sets the PHI is located. This includes a determination of whether or not the PHI that has been amended has been disclosed to any business associates for their use.
3. The Privacy Officer will direct the appropriate staff people to attach or link the notice of amendment and the amendment language to the original PHI.
4. All future disclosures of this PHI should include both the original and amended information.

Policy 12 Individual's Right to an Accounting of Disclosures of PHI

Procedure

Determining Which Disclosures Must Be Included in the Accounting

Every staff person, who as a part of their employment responsibilities, discloses PHI either internally or externally is responsible for reviewing the above policy, in particular the list of exceptions to the accounting requirement. Because this is a complicated subject (with many exceptions), whenever a staff person is unsure of whether or not a disclosure needs to be accounted for, he/she must either contact a supervisor or the Privacy Officer for assistance in making the determination or complete a "PHI Disclosure to be Included in Client's Accounting" form as described below.

Completing a PHI Disclosure Form

Disclosures of PHI that need to be accounted for may be made by multiple departments in the organization and by outside business associates. In order to organize and keep this information current, the attached form, "PHI Disclosure to be Included in Client's Accounting" will be completed each time there is a disclosure of the type listed in this policy.

1. The only exceptions to this are as follows:
    a. Information disclosed electronically from an electronic database, client medical record, or billing record where a system exists for recording and accounting for the disclosure, including the date, to whom the disclosure is made, and for what purpose do not need to be recorded separately on the above form.
    b. Business associates, who are permitted to make disclosures on behalf of the Davis Behavioral Health, do not need to complete a form for each disclosure. However, these business associates must have an internal system for accounting for disclosures, other than for treatment, payment, or operations
2. If a staff member is uncertain about whether or not a form needs to be completed, call the Privacy Officer or complete a form just in case.
3. The form, once completed, should be placed in the medical record, behind all authorization forms, in date order, with the most recent form on top.

Requests for Accounting

1. If a client or his/her healthcare representative requests an accounting, he/she should make the request in writing, preferably on the "Request for Accounting" form. In those cases

where the client is not willing or able to do so, Davis Behavioral Health staff should complete the form and ask the client to sign it indicating that he/she has been informed of costs, etc.

2. The form should be sent as soon as possible to the Privacy Officer. This is especially important because the agency must provide the accounting within the required deadline of 60 days from the date of the request. It is possible that some information needed for the accounting may be in archived records or beheld by business associates.

Completing an Accounting

1. The Privacy Officer, upon receiving the Request for Disclosure form, will request (these activities may be delegated):
    a. The client's medical record, or copies of all "PHI Disclosure to be Included in Client's Accounting" forms for the appropriate dates located in the client's medical record.
    b. The accountings located in any electronic database of the organization.
    c. An accounting from any relevant business associate.
2. Once the material has been gathered, the Privacy Officer will review each disclosure to determine if it is appropriate to include it in the accounting.
    a. Does each disclosure meet the requirements for a disclosure that must be accounted for?
    b. Is the disclosure to a health oversight or law enforcement agency and have they restricted any accounting to the client? See also below under "Disclosures Made to Law Enforcement or Health Oversight Agencies"
    c. Is all required information available?
    d. Does the accounting include disclosures for research purposes in which 50 or more individuals participated? See below Accounting for Research Disclosures.
3. The Privacy Officer will then list (in date order) the disclosures including the date of the disclosure, the name of person, the organization to whom the information was disclosed, a short summary of the information that was disclosed, and a short summary of the purpose of each disclosure. There are three exceptions to this:
    a. Multiple Disclosures to the Same Entity: Multiple disclosures made to the same person or organization for the same purpose will be accounted for with one complete entry for the first disclosure and a summary that includes the frequency

or actual numbers of disclosures in the time period requested by the client and the date of the most recent disclosure.

b. Accounting for Research Disclosures: in cases where 50 or more individuals are the subject of the research: Our accounting for disclosures will include:
    1. Name of the protocol or other research activity
    2. A description, in plain language, of the research protocol or other research activity, including the purpose and criteria for selection of particular records;
    3. A description of the type of PHI that was disclosed;
    4. The date or period of time during which such disclosure occurred, or may have occurred, including the date of the last disclosure during the accounting period;
    5. The name, address, and telephone number of the entity that sponsored the research and of the researcher to whom the information was disclosed; and
    6. A statement that the PHI may or may not have been disclosed.

In the event that it is reasonably likely that the PHI of a particular client has been disclosed for such a protocol or research activity, the Privacy Officer or his designee will, if requested by the client, assist him/her in contacting the entity that sponsored the research and the researcher.

c. Disclosures to the Secretary of Health and Human Services for compliance purposes or for any other disclosure allowed to be made without the client's permission. See also below, " Disclosures Made to Health Oversight or Law Enforcement Agencies".

4. The accounting will be delivered to the client in person or sent by mail.
    a. No fee will be charged for the first accounting in a 12 month period.
    b. For the second and subsequent requests for an accounting in a 12 month period, the client will be asked to sign the additional paragraph at the bottom of the "Request For Accounting" form indicating that they understand they will be charged a fee for this service.
    c. The Privacy Officer will instruct the appropriate staff person to collect the fee from the client prior to handing over the accounting or to hold the accounting from mail until the fee has been paid.

5. In all cases, every effort shall be made to complete and deliver the accounting to the client within 60 days from the date of the request. If this is not possible, the Privacy Officer shall send a written notice to the client, within the 60 day period, stating that:
    a. There will be a delay
    b. The reason for the delay
    c. The date the accounting is expected to be completed for delivery or for mailing. (In no case can this date be more than 30 days from the date the accounting was originally due.)

Disclosures Made to Health Oversight or Law Enforcement Agencies

If a disclosure is made to a health oversight or law enforcement agency in accordance with the No Permission Policy, the following procedures for accounting for this disclosure will apply:

1. If the health oversight or law enforcement agency makes an oral request to withhold the disclosure this will be noted on the "PHI Disclosure to be Included in Client's Accounting" form as follows:
    a. Date of request
    b. Name of Agency Representative requesting the withhold
    c. Contact phone number for Agency Representative
    d. Name of agency requesting the withhold
2. The person, who receives the request for the withhold is responsible for documenting the above on the form.
3. The person, who receives the request for the withhold, must inform the Agency Representative that the oral request will be honored for 30 days only and that any further withhold requires a written request.
4. If the health oversight or law enforcement agency requests a withholding of accounting in writing, the request will be stapled to the "PHI Disclosure to be Included in Client's Accounting" form and will be included as an attachment to any copy of the form requested by the Privacy Officer or other person delegated to assist with compliance with this policy and procedure.

Uses and Disclosures

Policy 13 Other Individual Rights – Right to Restrict Uses and Disclosures of PHI

Procedure

Approval, Notification, and Acting On a Restricted Consent

1. The right of a client to ask for a restriction on the use and disclosure of their PHI for treatment, payment and operations is included in the organization's privacy notice.
2. If a client asks about requesting a restriction, he/she should be informed:
    a. That the organization will not accept any restriction that would prevent billing, interfere with our direct treatment of the client, or prevent us from complying with the Privacy Rule, or other laws and regulations.
    b. By a professional member of our healthcare staff, the possible or potential consequences, if relevant, to their treatment.
3. If the designated staff person agrees to the restriction, he/she will be responsible for completing the Request for Restriction form attached to this Policy and sending it to the Privacy Officer.
    a. The Privacy Officer must respond within two business days to the request in order to not unduly delay continued treatment.
    b. The Request to Restrict should be initialed by the Privacy Officer as approved, a copy kept in their records and the original sent back to the designated person who initially completed the form. (Note: the form should not be sent back to the client's primary provider unless they are a designated staff person as described in 2.b. above.)
4. The designated person receiving the form will then be responsible for:
    a. Filing the completed and approved "Request to Restrict" form in the client's medical record;
    b. Communicating the content of the restriction to appropriate staff;
    c. Developing a plan for staff to abide by the restriction while performing TPO. The original of this plan and the communication to staff about the restriction will be kept in the medical record attached to the "Request to Restrict" form. A copy of this same information will be sent to the Privacy Officer for his files.

5. **The restriction will not be in force unless the client has signed the "Request to Restrict" form.**
6. The outside of the medical record will be flagged "Resticted Uses and Disclosures Approved".
    a. Paper records will have a colored sticker applied to the outside of the chart with Restricted Uses and Disclosures Approved written on it.
    b. Electronic records will be flagged to notify anyone accessing the chart that there is a restricted consent.
7. The billing and other client databases as appropriate will be flagged to notify staff of the restriction to the uses and disclosures.
8. Requests for additional restrictions or modification of the current restriction will require that all the steps in 2 through 7 above be repeated.
9. Anyone accessing or copying a record or database must:
    a. Check in every case to see if there is a restriction to uses and disclosures;
    b. Thoroughly read the restriction and determine if it applies to the use intended (Any employee who is unsure should consult the Privacy Officer or other clinical supervisor before proceeding.); and
    c. Determine how best to proceed while complying with the restriction, (e.g. removing certain documents before copying, not disclosing certain information at treatment team meetings, etc.).
10. If a request for a disclosure comes from an outside entity asking for information that is restricted, the staff person responsible for the disclosure should send back the information requested that is not restricted and attach a note or orally inform the requestor that: "Your request for a disclosure has been partially fulfilled because you have requested information that the client has asked us to restrict. Any additional questions should be directed to the client."

Terminating a Restriction

1. Terminating a restriction with the client's agreement:
    a. If the client agrees to a one-time termination of their restriction for a specific purpose, the disclosure should be documented on the Request to Restrict form or attached to it. The documentation should include the client's oral or written consent, the reason for the disclosure, the date, the signature of the clinical person responsible for the disclosure, and the client's signature, if

possible. A copy of the documentation must be sent to the Privacy Officer for his records.

b. As treatment progresses, the client may more clearly understand the impact of the restriction on his/her treatment and may no longer wish to keep the restriction in place.
    i. This conversation can be initiated by an employee.
    ii. The removal of the restriction should be documented on the original Request to Restrict form or attached to it. The note should include the information that the restriction is being removed for all PHI.
    iii. In an electronic record, the flag should be removed, but the historical information about the restriction must be saved.
    iv. In a paper record, the flag on the front of the chart should be removed.
    v. Any flags in any of the other databases can be removed.
    vi. A copy of the documentation must be sent to the Privacy Officer for his records.

2. Terminating a restriction without the client's agreement:
    a. Restrictions can be terminated by the agency. In these cases, only PHI developed after the date of the restriction will be free of the restriction.
    b. Terminating a restriction, without the client's consent, should only be done after the client has been contacted and his/her agreement with the termination has been sought.
    c. Terminations without the client's consent should only happen if the client's clinician and his/her supervisor believe that (the client's clinician should seek the approval of the Privacy Officer and/or ELT representative to terminate the restriction.):
        i. The restriction is interfering with the client's treatment to a degree that service quality is being negatively impacted;
        ii. The restriction compromises the organization's ability to provide medically necessary care; or
        iii. The restriction requires the organization to do something that may violate regulation or law.

d. The client should be informed either orally or in writing. If orally, the client's provider should document the notice on an attachment stapled to the Request to Restrict form. The documentation should include the reason for termination, approval received from Privacy Officer and/or ELT representative, method for notifying client, and effective dateof termination.
e. The flags in the medical record and other databases should note the date of termination of the restriction, but the flag should remain in place prior to the termination date of the restriction.

Emergency Situations

In situations when the individual is in need of emergency treatment, the restricted PHI is needed to provide the emergency treatment, disclosure of restricted PHI is allowed.

1. The staff person, who will be responsible for the disclosure, must make a reasonable attempt to get the client's agreement to release the restricted information (if the client can consent or the attempt will not interfere with treatment). This should be documented in a progress note.
2. If the disclosure is oral, the staff person will inform the emergency provider that the PHI disclosed restricted information and that disclosures must be made in compliance with the restriction going forward. This should be documented in a progress note.
3. If the restricted information is sent electronically or in writing, notice should be given in writing (or electronically) to the emergency provider that this is restricted information and that disclosures must be made in compliance with the restriction going forward. A copy of this written notice should be kept in the medical record.

Uses and Disclosures

Policy 14 Other Individual Rights – Confidential Communications

Procedure

1. The client's right to confidential communication will be explained in the Privacy Notice.
2. Each client will be asked, at the time of his/her initial visit for each separate episode of care, if he/she wishes to exercise the right to confidential communication.
3. If confidential communication is requested, the request and approval should be noted on the client information/demographic form located at the front of the record or in the designated field in the electronic medical record. The following information will be included with the demographic information in the medical record:
    a. Is confidential communication being requested?
    b. Is an alternative address to be used for communication?
    c. Can postcards/letters identifying organization be sent to the alternative address?
    d. If the address is not restricted, can postcards or letters that identify the organization be sent there?
    e. Is an alternative phone number to be used for communication?
    f. Are there times of the day in which we are restricted from calling the client? List times.
    g. Can we leave a message? Can the message list the name of agency/provider?
    h. Can we leave a blind message with a phone number only?
4. Approval for a confidential communication can only be given if the client gives Davis Behavioral Health adequate information to allow the client to be contacted and makes adequate arrangements for services to be billed.
5. The following actions should be taken if a confidential communication has been requested and approved:
    a. The outside of the paper medical record should be flagged with a sticker that states confidential communication.
    b. Electronic records should have a field that flags the record as one where the client has requested confidential communication.
    c. Any other client database, for example the billing database, should be flagged as well on the client contact screen and other appropriate screens.

6. Prior to contacting the client, all employees should check one of the above to see if a flag exists. Employees who do not have access to any of the above three sources of information should not be responsible for contacting clients.

Policy 15 Administrative Requirements -- Documentation Procedures

Documentation Maintained by Privacy Officer

The Privacy Officer, or his designee, will be responsible for maintaining in files the current and historical copies of certain HIPAA compliance documents described below. Historical documents should be kept for a minimum of six-years from the effective date listed on the document or the date it was last in effect, whichever is later. The documents may be in either paper or electronic form or both.

1. Copies of versions of the Privacy Notices used in the organization. Each document that is no longer in use should have an effective date and a retirement date listed directly on the document. In addition any memos instructing staff on the destruction of old or out of date versions and the effective date of the new shall be kept with the version discussed in the memo.
2. Copies of all policies and procedures specific to the organization's privacy practices. Each policy and procedure no longer in use shall have an effective date and a retirement date listed directly on the document. The list of Policies and Procedures covered by this paragraph are as follows: HIPAA Policies and Procedures.
3. A list of the documents and/or files that were considered to be a part of the designated record set. Each list should have an effective and retirement date listed at the top of the document. This list should be reviewed and updated annually or as necessary. The file should include the current list and all lists that have a retirement date of six-years or less.
4. Copies of all complaints about privacy practices or breaches of privacy practices, including a copy of the complaint and its disposition. These documents should be kept for at least a six-year period, using the date of the disposition as the effective date, unless they are applicable to a current or on-going audit or investigation.
5. A copy of each accounting of PHI disclosures given to clients kept in a file for six-years from the date the disclosure was given to the client.
6. A list of persons responsible for various critical procedures relating to the privacy practices of the organization. The list should be reviewed annually or updated as necessary. The file should include the current list and all lists covering the six prior years. The list should include the position, responsibilities and names of the individuals where this is practicable, and should include at least the following:
    a. Name of Privacy Officer (include other positions held if this is not a full time position);

b. Persons responsible for receiving and processing requests by clients for access to the designated record set;
c. The titles of persons or offices responsible for approving client amendments to the designated record set;
d. The title of persons or offices responsible for organizing and providing an accounting of PHI disclosures at the request of clients;
e. The title of persons or offices designated to receive and process privacy complaints;
f. Persons listed below under sections 2 and 3 below who are responsible for maintenance of certain documentation required by the rule; and
g. Any others the organization determines to have responsibility for procedures related to the Privacy Rules.

Documentation Maintained by Other Departments

The Privacy Officer shall be responsible for ensuring that the documentation listed below is being kept for a period of six-years by those responsible. The responsibilities for oversight by the Privacy Officer include ensuring that the documentation is being kept in the correct format and location with the approved content and organized in the appropriate manner. The Privacy Officer shall develop a method for oversight that includes personal reviews of the actual documentation. All documentation listed below shall be kept for a minimum period of six-years from the date the documentation is created.

1. HIPAA related training: the training department shall be responsible for maintaining copies of the following:
    a. Attendance Sheets
    b. Handouts
    c. Curriculum
    d. Evaluations
2. Employee Sanctions: The Human Resources department shall be responsible for, including in the personnel files of the individual employees, documentation of any disciplinary procedures resulting from privacy-related non-compliance. The Human Resources Director will be expected to be able to give to the Privacy Officer an accounting at regular periods but at least annually of the numbers of sanctions or disciplinary actions related to privacy, types of sanctions or actions, and the reasons for

the sanctions or actions. The Human Resources Director shall keep a copy of these reports for a period of six-years.

Documentation Maintained In Designated Record Set

The following information shall be kept in the medical record and/or the files of the designated record set. The Privacy Officer will, through various auditing and monitoring procedures performed personally or delegated, ensure that this documentation is being kept in compliance with the written policies and procedures that govern the creation and maintenance of this information. All the information below, unless otherwise noted, shall be kept for a minimum of six-years from last effective date regardless of conflicting organizational policy. Any destruction of the documentation listed below shall be done in accordance with organizational procedure regarding the destruction of documents. During that period, the responsibility for maintaining the documentation listed below will fall to the Privacy Officer.

1. The signed, written acknowledgement of receipt of the Privacy Notice or documentation of good faith efforts made to obtain such acknowledgement in those cases where a signed, written acknowledgement could not be obtained;
2. Any documentation related to restrictions as requested, approved/denied or terminated, including determination that the medical record, the billing record, and other appropriate client data bases have been appropriately flagged to notify employees of the restrictions. A separate database of all current restrictions will not be kept. These records should be kept for at least six-years from the date of creation.
3. Any authorizations for the use or disclosure of PHI.
4. Any documentation related to the request, approval, or denial (and any related appeals) of amendments by the client to their designated record set. These records should be kept for at least six-years from the date of creation.
5. Any documentation related to the request, approval, or denial (and any related appeals) of requests by the client to have access to their designated record set. These records should be kept for at least six-years from the date of creation.
6. Any documentation related to disclosures without an authorization (i.e., for law enforcement, health care oversight, research, etc.).

Policy 16 Administrative Requirements – Complaint Process

Procedure

See Grievance Policies

Policy 17 Administrative Requirements – Training of the Workforce

Procedure

HIPAA training will be incorporated into the existing training vehicles the organization has including:

- The HIPAA implementation and training plan
- Orientation
- Compliance Training

General Requirements

1. All training curriculum developed on privacy practices or the Privacy Rules must be approved by the Privacy Officer.
2. Attendance will be taken at all trainings.
3. Attendees will be asked to complete evaluations of all trainings. The evaluations will be reviewed by the trainer or training committee, and changes to the curriculum will be made based on these evaluations.
4. All handouts will include information on how to contact the Privacy Officer and where to get additional information.
5. Copies of all attendance sheets, handouts, slides and curriculum, and evaluations will be kept in the files of the training office for six-years from the date of the training.

Training the Current Workforce

1. By March 1, 2003 the HIPAA Implementation Committee, with approval from the Privacy Officer, will develop a training plan for training the current workforce on the organization's privacy practices and the HIPAA Privacy Rule. This training plan will include the following:
    a. An analysis and recommendations for role-based training curriculum so that groups of like employees can be targeted for appropriate levels of detail and scope of responsibilities. For example, all maintenance staff may be able to be together in one training.
    b. A timeline for developing the curriculum for each group of employees, including training dates, training times for 24 hour staffed sites, dates notices will go out, locations, type of training (i.e., on-line, workshop, self-study), primary person

responsible for developing the curriculum, dates, handouts, suggested trainers, and curriculum are to be handed in.

c. Primary persons responsible for organizational training.

2. The training plan must allow for the training of all staff no later than April 14, 2003.

Training New Staff

All new staff will be trained on the agency's privacy practices and the HIPAA Privacy Rule within 30 days of employment.

On-going Training

1. Any major changes to the organization's privacy practices or changes to the Privacy Rule that will result in material changes to policy and procedure will require the development and implementation of a training plan by the Privacy Officer. This plan may focus on specific programs or can be agency-wide in scope depending on the changes required.
2. The training methods can vary with the content and can include workshops, self-study modules, on-line training, staff meetings, etc. The trainings should be completed within 30 days after the implementation date for the changes.
3. The Privacy Officer or his designee is encouraged to develop on-going reminders of the organization's privacy practices through poster campaigns, memos, and newsletter.